

# “Be Well Partners in Health”

## *Achieving Accountable Care in the Safety Net*

### Addiction and Chronic Illness

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# Case Studies, or *Why We Are Here*

- *46 yo man with advanced heart failure, on kidney dialysis for diabetic nephropathy.*
  - *Addiction interfered with Rx chronic conditions*
  - *Unfunded until disability*
- *29 yo woman in preterm labor, no prenatal care, acute withdrawal from heroin.*
  - *EtOH/weed in HS, EtOH/Coke in College*
  - *Several arrests, 2 kids w/DCFS, no Rx*
- *8 years later her little boy is repeating 2<sup>nd</sup> grade, now expelled for aggressive behavior.*
  - *Born at 26 wks, left NICU “intact”*
  - *Foster care shuffle, lead poisoning, etc.*
- *Theme: Amazingly Accountable Rescue Rx, but...*



*If health care were an Olympic sport, how would the U.S. do in the medal count?*

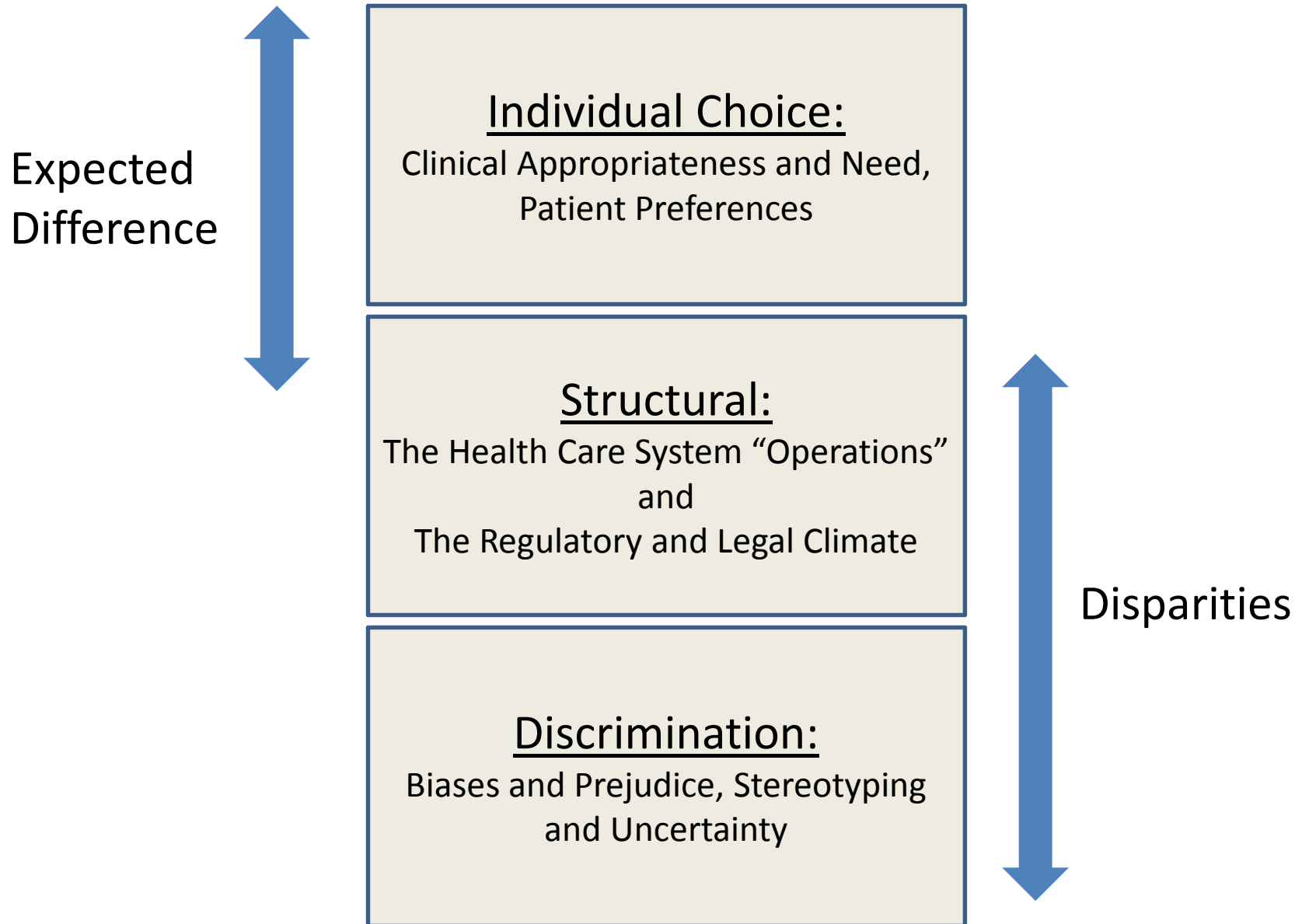
*#1 in “Rescue” care*



*#37 in Population Health, Especially?*

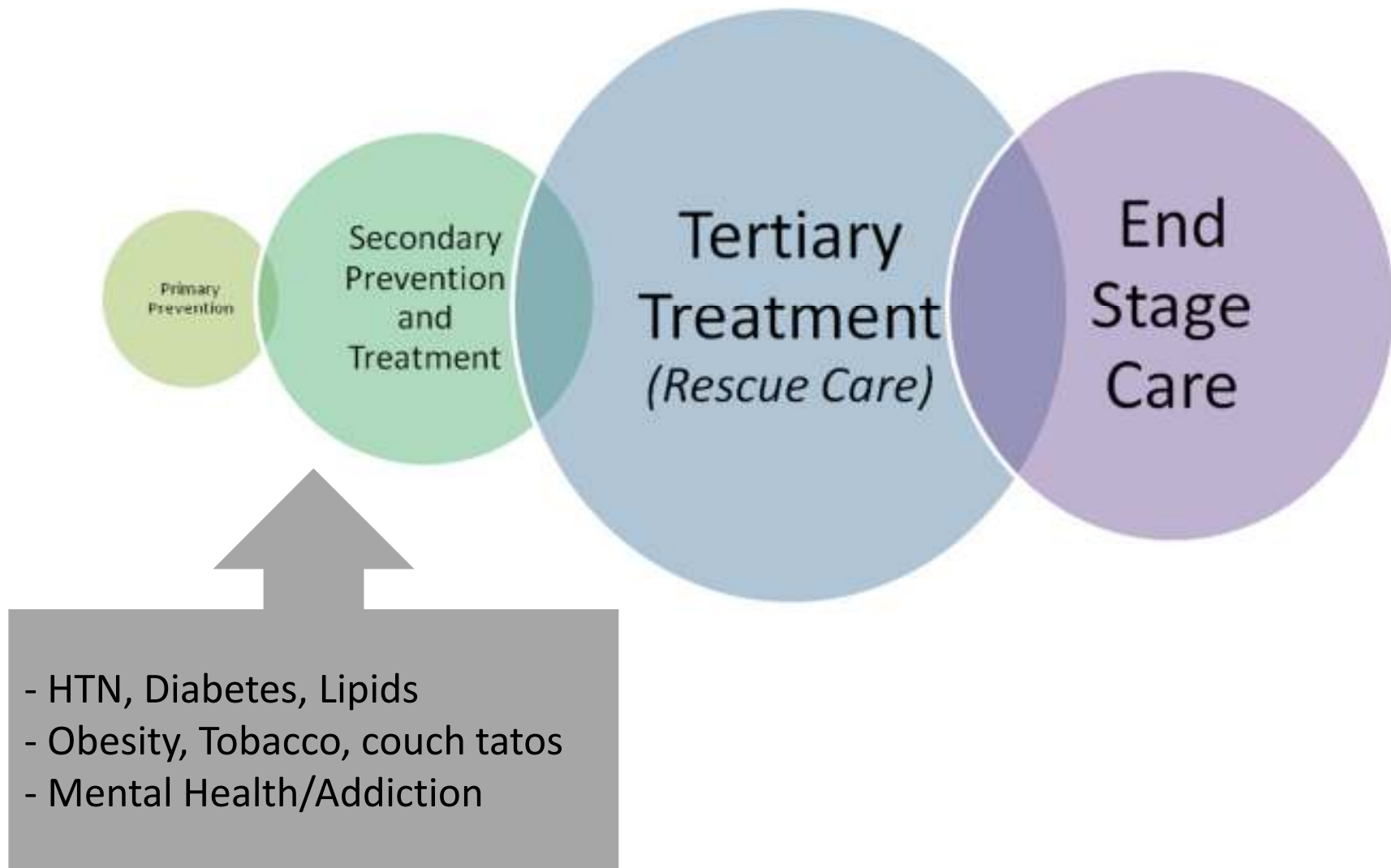
- Minorities, poor and social barriers*
- Chronic illness, mental health, addiction*

## *Determinants of Variation in Outcome*



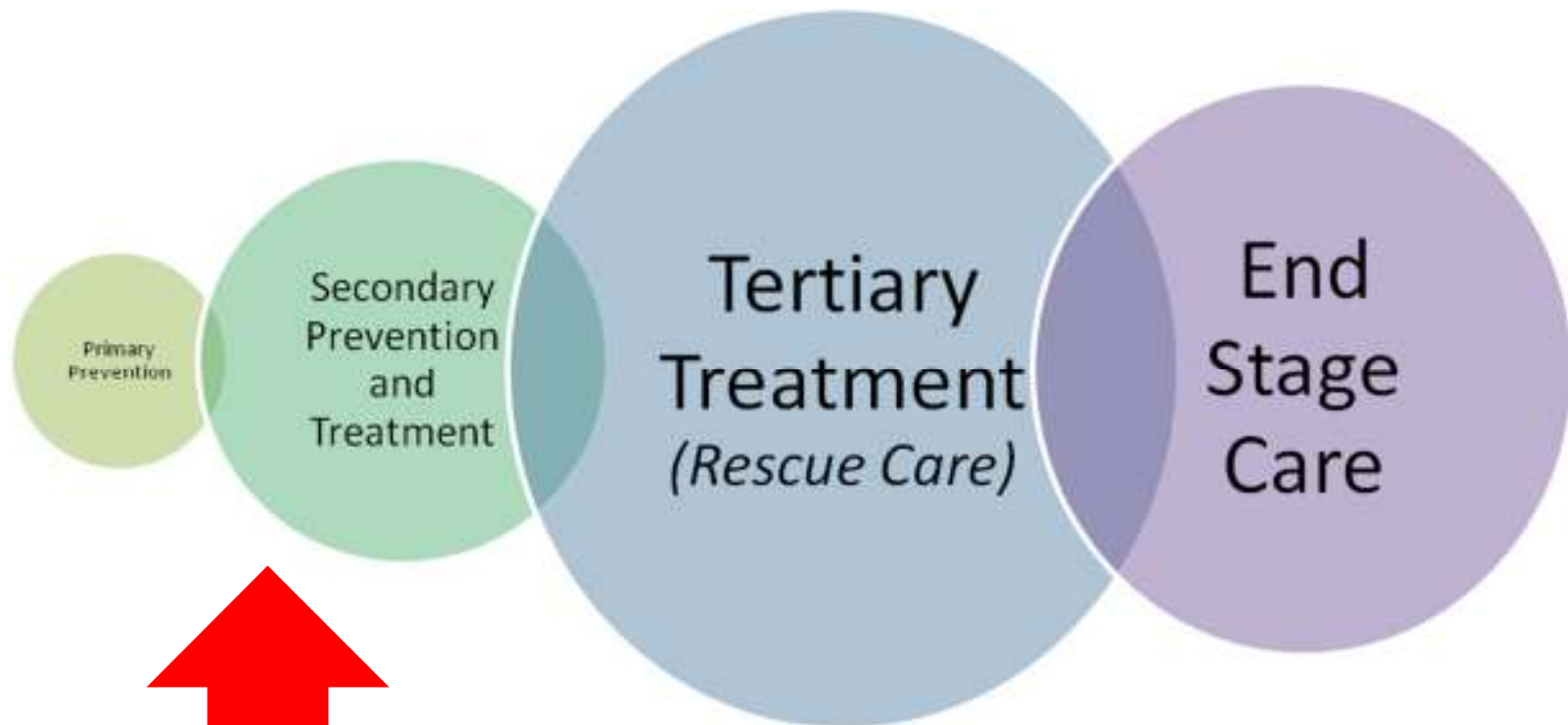
# Allocation of Healthcare Resources and Workforce


*...what does it take to get our Gold medal care?*



# Allocation of Healthcare Resources and Workforce

*...what does it take to get our Gold medal care?*



- 
- **Uncontrolled** Conditions
  - **Persistent** Obesity, Tobacco
  - Addiction **not Managed**
  - Mental Illness **not Treated**

## *“Be Well” Partners in Health*

- Enrollee (patient/client) Centered, Coordinated
- A Team based, multi institutional Collaborative
- Bridge care gaps, promote self management
- Evidence based and comprehensive scope
  - Risk Stratification, Intensive education/training
  - Care managed w/standardized processes
  - Electronic Information Management

# *“Be Well” Partners in Health*

- *Main Partners:* Norwegian American Hospital, MADDO Healthcare, Methodist Hospital of Chicago, Neumann Family Services
- *Target population:*
  - Adult and senior Medicaid recipients with serious mental illness
  - Co-morbid substance abuse problem, a chronic health condition or developmental disability, and/or
  - History of medical or psychiatric hospitalizations and excessive emergency room utilization



# *Outcomes*

- Improve self-management skills and abilities
- Ensure timely preventative health practices
- Improve quality of care and satisfaction
- Achieve cost efficiency, including a focus on avoidable hospitalizations/re-admissions.

# *Anticipated Barriers*

- System we have (now) is designed perfectly to get the results we are getting (now).
- Systems change = Outcomes change
- Services, resources, staff, capacity, culture
  - Rescue focused silos built to churn fee for service
  - Olympian level resistance to change
- Independent providers (doc, organizations)
- OMG!

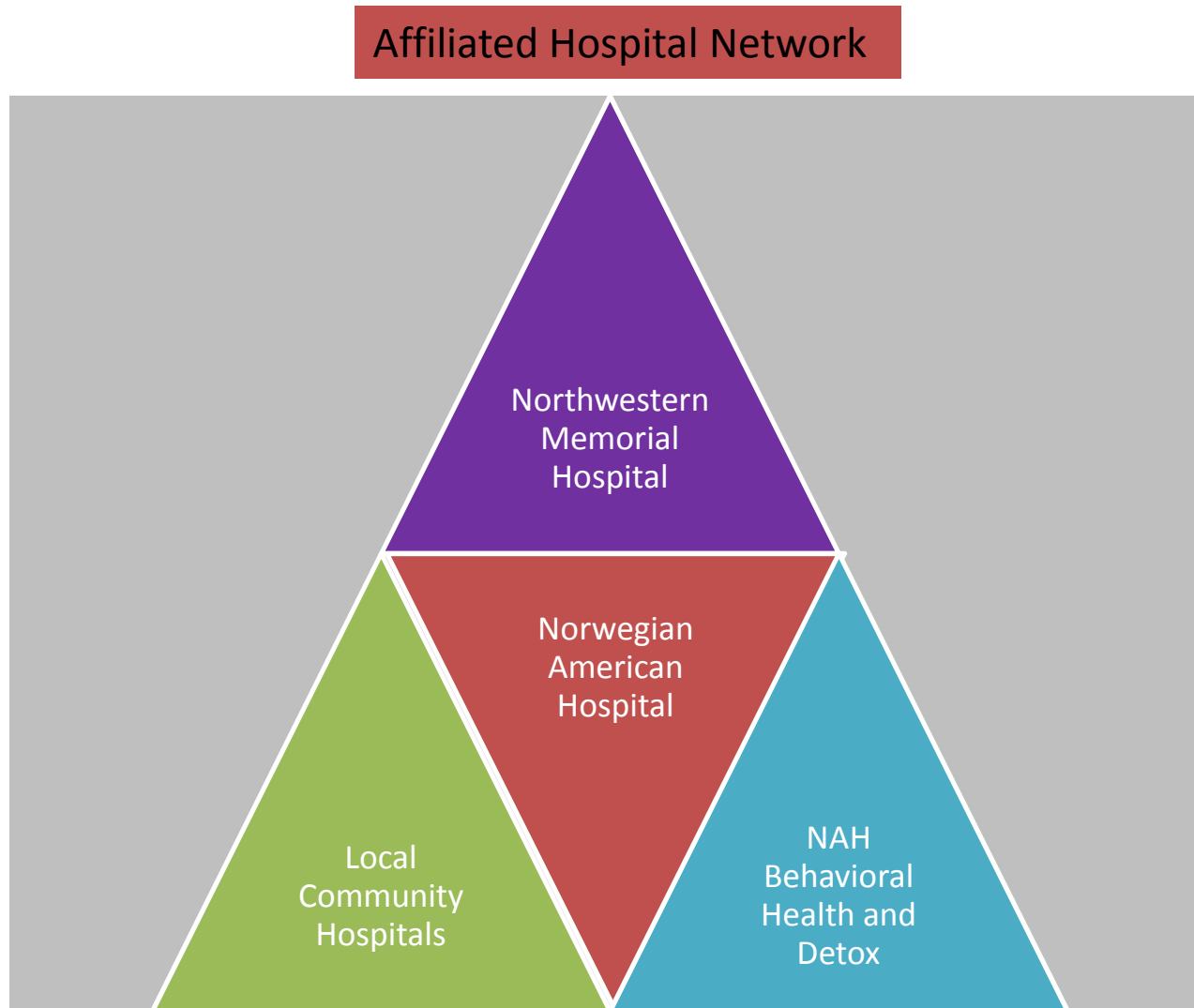
## System Change:

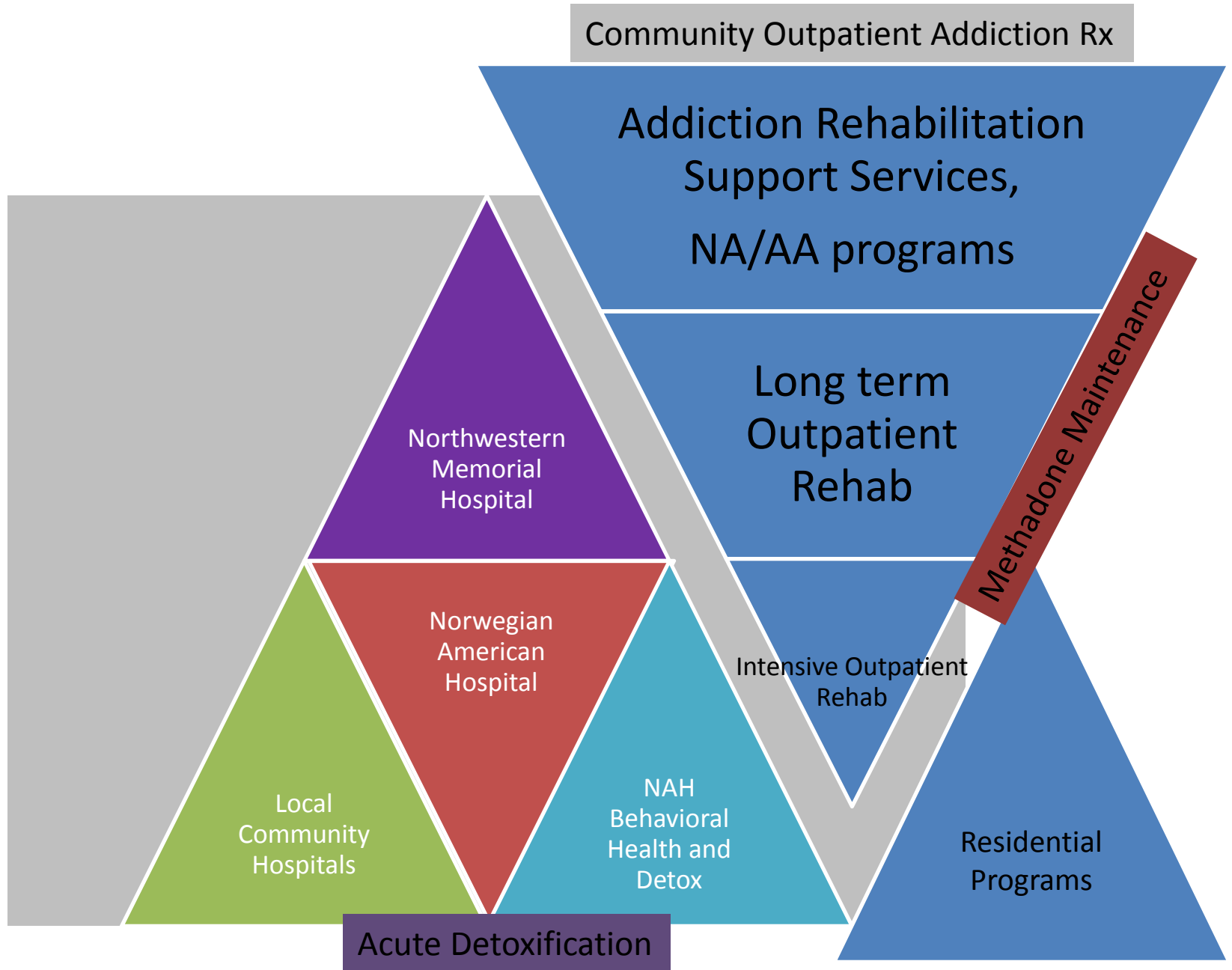
### *Build a Clinically Integrated Network*

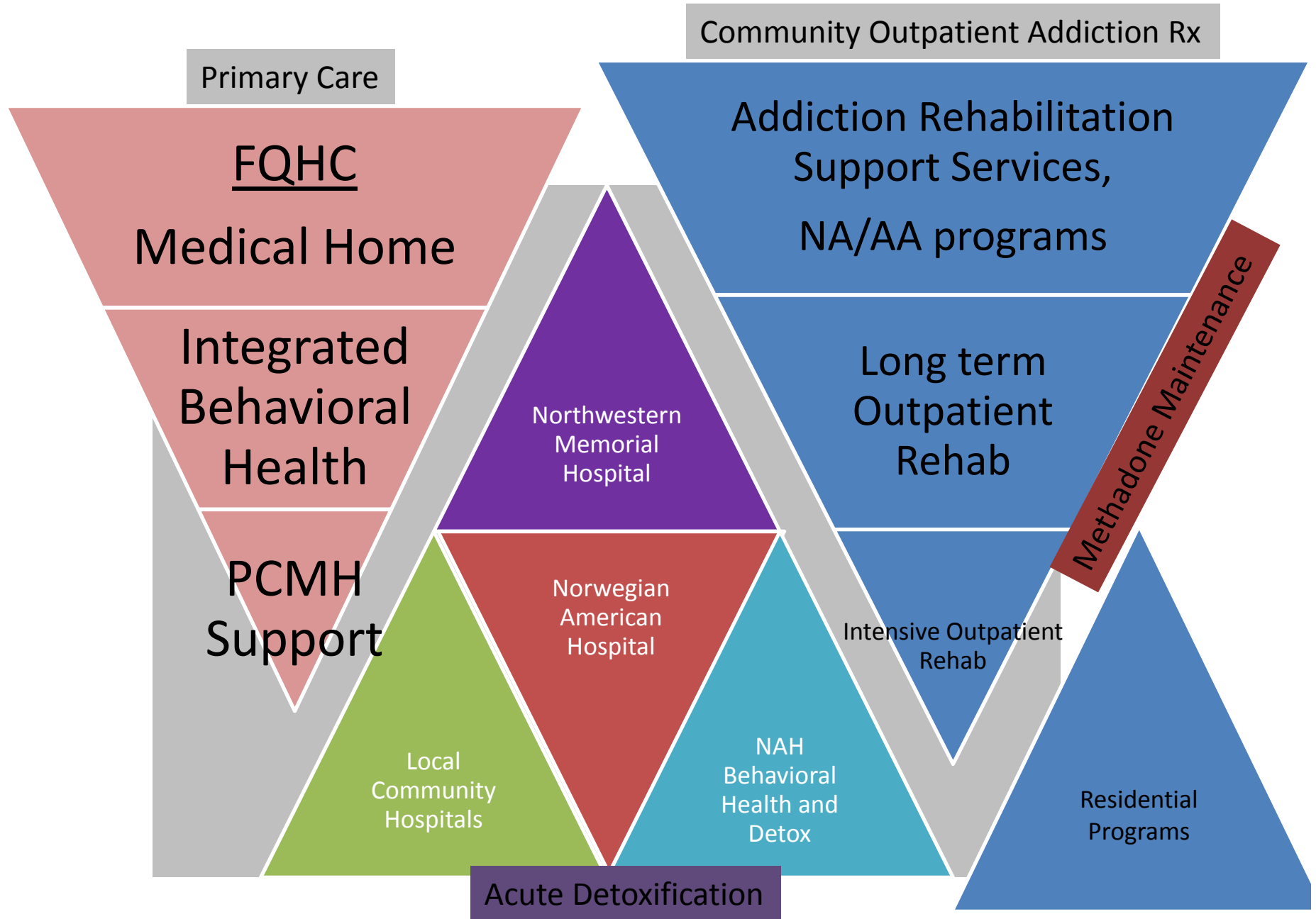
*My patient - wherever they are, all the time*

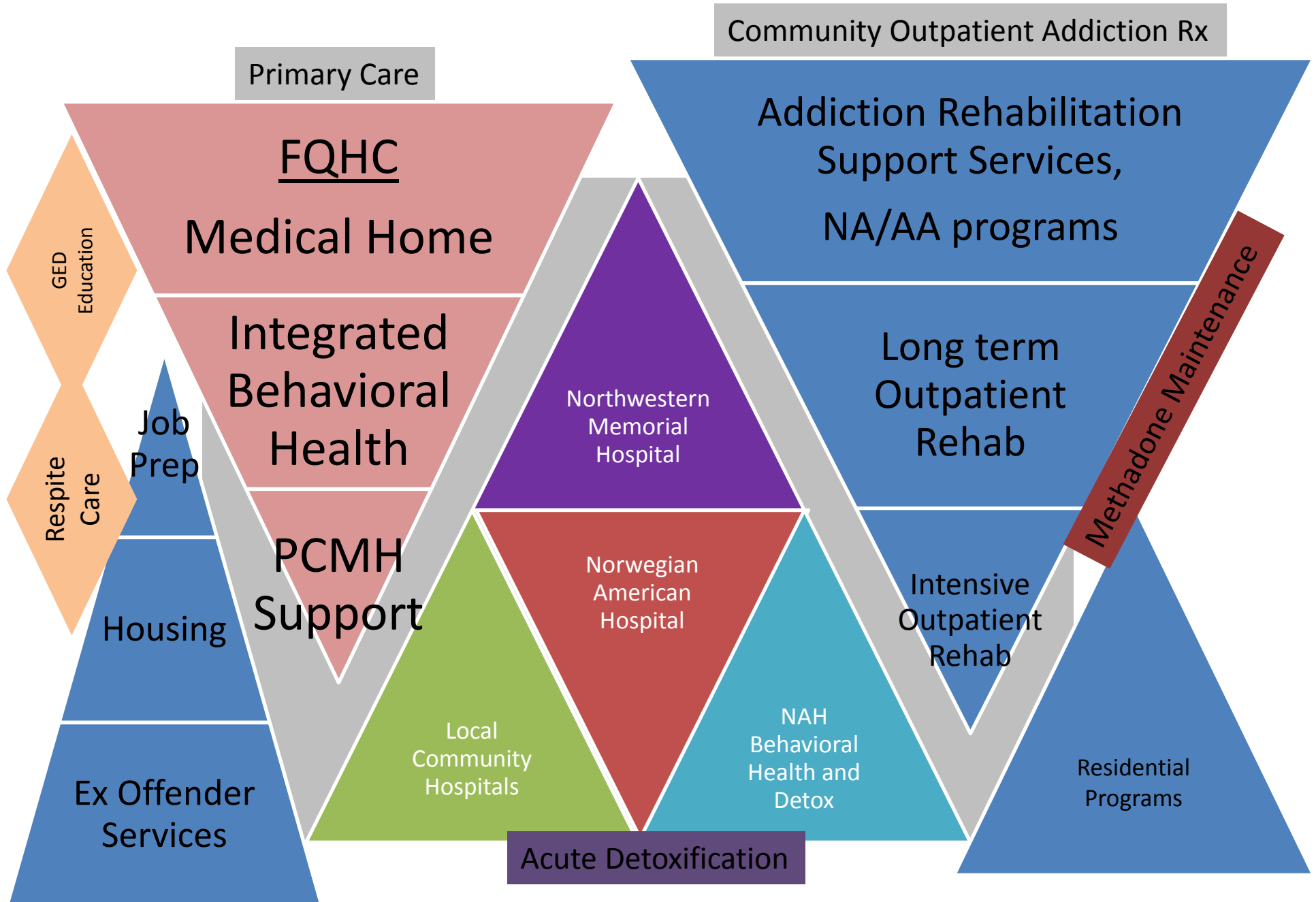
- States role: Help!
- Clinical scope: Comprehensive Integrated Primary Care
- Community and Hospital, aligned and integrated

## PATIENT CENTERED CARE:GEOGRAPHICALLY BASED REGISTRY









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